Medical College of Virginia Physicians Professional Liability Program

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Who are we?

- John W. Seeds, MD- Chair of Ob/Gyn from 1996; member of MCVP Malpractice Policy Committee since 1996; Member of Governor's ED2 Working Group on Rural Access to Obstetrical Care, Malpractice Subcommittee
- Carl Gattuso- Senior Executive Vice President of VCU Health System and founding administrator of MCVP Professional Liability Program

Malpractice Crisis?

- You have heard there is no malpractice crisis
  - Availability good – 7 companies offer new/ 12 renew
  - Rates not excessive
  - Rates less than some surrounding states
  - More tort reforms not needed – already strong reforms
  - Stable low cost tort system
  - No facts support claims as driver of rates
  - Rate rise due to business cycle/investments
  - Award caps deny relief to the injured

Why Are We Losing Ob's?

- Dozens of Ob/Gyn providers have left the state or dropped Ob over the past two years
  - Many rural Ob's have left; hospitals have closed units
  - Malpractice insurance is one of the greatest single operational cost items
  - Rates rising at several times the rate of rise of other operational costs: **17%=>50%=>43%=>16%***
  - Compensation flat or falling
  - Rural practices smaller and heavily Medicaid
  - Hospitals no longer see small Ob unit as feasible
    - A crisis of access now in rural areas; soon in urban

***State Volunteer Insurance Co.**

Rising Rates

- The perfect storm
  - Rising cap => increases whole spectrum of claims *
  - Downturn in investment income
  - Diminished competitive pressure – loss of two carriers
  - Growth in market share requires growth in reserves
  - Increased reinsurance rates – ? related to 9/11 and recent natural disaster losses
  - Inflation of health care costs
  - Catch up with rising loss curve

*State Volunteer Insurance Co.

Solutions

- Tort reform
  - Estimates that adoption of California style reforms would lead to 40% rate reduction
  - States with caps do show diminished rate of rise; Texas a drop
  - "Level the playing field"; but some think its level now
- Increase provider compensation
  - If not indexed to inflation would be temporary patch
  - 50% of babies born under Medicaid => 3000 lb gorilla
- Initiate state backed risk management plan ??????????
- Increase insurance company regulation ????????
- Liberate midwives from "supervision" ??????
- Increase hospital compensation for single source hospitals

MCVP Liability Program

- Initiated in 1989 due to crisis
  - Liability pool established
  - Claims made policy format
  - At five years funded at high level of confidence
  - Two levels of medical claims review mandatory
  - Annual actuarial review of status and premiums
  - No use of state funds
  - Premiums paid by department from clinical income
  - 518 medical providers and 109 allied health care professionals covered in FY 2005
  - Dropped excess reinsurance in FY2005

Medical Review

- Malpractice Claims Committee first review
- Malpractice Policy Committee final decision
  - Mandatory review
  - Outside expert review
  - Decision to defend or attempt settlement
  - Ongoing review of discovery
  - Ongoing reassessment of progress
- In house and outside counsel
- Identification of claims clusters and review of clinical practices

Elements of Success

- Settlement authority with Policy Committee
- Defend good medicine (1 lost court case in 15 years)
- Aggressive risk management and CME
- Review unexpected adverse outcomes
- Aggressive investigation/outside review
- Closed population of insured
- Flexibility to write policy to specific needs
- In house risk manager and attorney
- Non profit (no margin to protect)
- Aggressive management of investment pool
- Low administrative costs

Key Elements

- Mandatory case review at two levels
- Aggressive defense of good medicine
- Aggressive risk management and CME
  - A high risk environment
- Controlled pool of insured
  - Regular peer review
  - “selective” recruitment
- Close control of investment strategies

MCVP Liability Rates

- Annual review
  - Loss potential of known claims
  - Loss potential of unknown claims
  - Loss potential of year to come
  - Total $ needed to cover possible losses
    - 50%tile
    - 75%tile
    - 90%tile

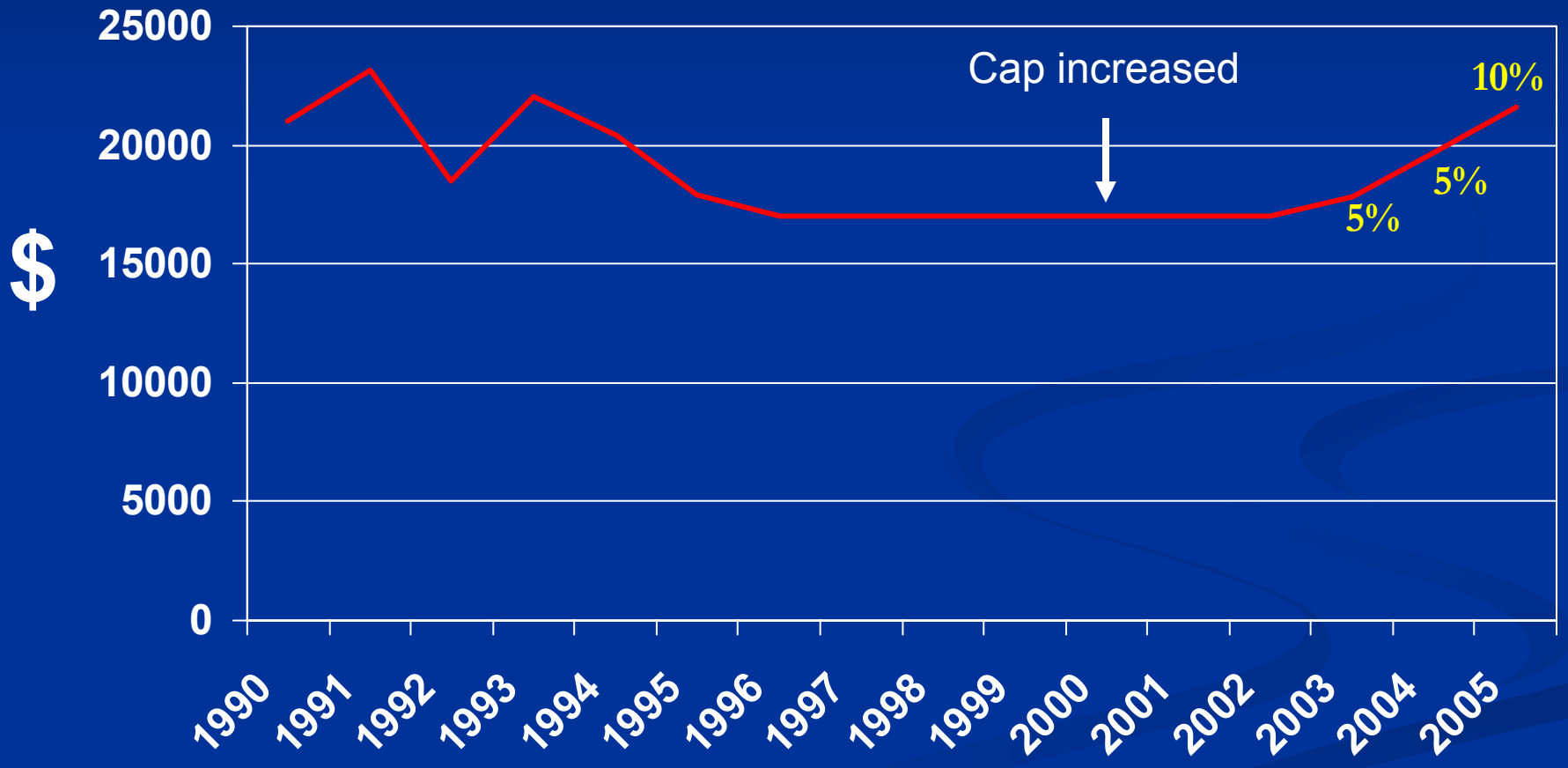
Risk Ratings

Specialty	Class	Multiplier
Anesthesiology	5	2.17
Dermatology	2	1.50
Emergency Med	4	2.45
Family Practice	1	1.00
Internal Medicine	1	1.00
Neurology	1	1.00
Ob/Gyn	**7**	**6.00**
Orthopedics	6	5.03
Pediatrics	2	1.50
Psychiatry	1	1.00
Radiology	1	1.00
Surgery	3	1.93
Neurosurgery	8	8.20

Base rate x Multiplier = Premium

Current base is <$4000.00

Ob/Gyn Premiums 1990-2005



What might we learn?

- Rising cap raises rates
- Mandatory medical review of claims
  - Faster compensation of valid claims
  - May reduce frivolous losses
  - Prior expert certification may play a role
- Aggressive risk management
  - Identification of bad outcome clusters
  - CME and peer review improves care
  - Regional medical review panels are one approach
- Profit adds to cost

Op-Ed

- Inaction is not an option
- Access to obstetrical care in the Commonwealth is rapidly eroding in rural areas with urban areas are close behind
- Obstetricians (all physicians) are small businesses with uniquely controlled compensation and runaway costs
- The Commonwealth has a compelling public interest to preserve access to care whatever you believe to be the cause of this crisis